CCL 053
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KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
BUREAU OF CHILD CARE AND HEALTH FACILITIES
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MEDICAL RECORD FOR CHILDREN IN 24 HOUR CARE FACILITIES

(School Health Form or the KAN Be Healthy Form May Be Used)

Name: _____ Birthdate: _____ Male/Female: _____

Address: _____ City: _____ Zip: _____

Parent/Guardian: _____ Work Phone: _____ Home: _____

Child lives with: _____ Work Phone: _____ Home: _____

Number in household: _____ Type of family housing: _____

Physician: _____ Date of last examination: _____

Dentist: _____ Date of last examination: _____

Eye Doctor: _____ Community Services: _____

School: _____

FAMILY HEALTH HISTORY

Response Codes: ***M = Maternal*** ***P = Paternal*** ***S = Sibling*** ***N/A = Not Applicable***

	Code	Comment
1. Are there any chronic illness problems in your family such as heart disease, diabetes,		
2. Does any family member have a vision defect, hearing loss or spinal deformity? Comment.		

CHILD/ADOLESCENT HISTORY

Response Codes: ***Y = Yes*** ***N = No*** ***NA = Not applicable***

1. Birth weight _____ Were there any pre-natal or delivery problems with the child?		
2. Did this child walk, talk and develop at the usual time?		
3. Does this child/adolescent:		
a. See a health care provider regularly?		
b. Use any medication, drugs or alcohol?		
c. Have a history of any hospitalizations, surgeries or emergency room visits?		
d. Have a history of any childhood diseases/illnesses?		
e. Have a history of other communicable diseases?		
f. Age menarche _____ Have a history of menstrual problems?		
g. Have a history of vision, speech, hearing or communication problems?		
h. Have a problem with being tired or overactive?		
i. Have any emotional or behavioral problems?		
j. Need any special help in school or day care?		
k. Have sexuality concerns?		
l. Have any chronic illness or disabling problems with:		

Headache	___	Convulsions	___	Diabetes	___	Earaches	___	Back/spine/	
Colds/sore throat	___	Rheumatic fever	___	Genitalia	___	Oral/dental	___	extremity problems	___
Heart/lung disease	___	Allergies/Asthma	___	Digestive	___	Urinary/bowel	___	Other	___

List present concerns of child/parent/guardian/foster parent:

Immunization: Record date of each dose received (mm/dd/yy)						***Required**			****Recommended**	
	1st	**2nd**	**3rd**	**4th**	**5th**		**1st**	**2nd**	**3rd**	**4th**
DPT (Diphtheria, pertussis, tetanus)*						**MMR** (Measles, Mumps, Rubella) *				
Td/DT *						**HBV** (Hepatitis B) **				
OPV or IPV (Polio) *						**TB** (Skin Test) *	Date	Result		
Immunization: Record date of each dose received (mm/dd/yy)						***Required**			****Recommended**	

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments.

Height	_____	Weight	_____	Hgb or Hct	_____
Pulse	_____	Blood Pressure	_____	Lead	_____
Urinalysis	_____	Sickle Cell	_____	Other	_____
Tuberculosis	_____	Head Circumference	_____		

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

1. Nutritional Evaluation (all ages - each screen) (• if applicable) Nutrition/WIC Questionnaires available from (785) 296-0092.
   ☐ Enrolled in WIC ☐ Receiving Vitamin Supplement with iron ☐ Without iron ☐ Fluoride Supplement
   Food intake review. Results:
   milk/milk products (breast-fed/type of formula) _____
   fruit/vegetables _____
   meat, beans, eggs _____
   breads, cereals _____

	Type of screen				
2. Development	_____	Results	_____		
3. Speech	_____	Results	_____		
4. Hearing	_____	Results	_____	Date of last screen	_____
5. Vision	_____	Results	_____	Date of last screen	_____

Significant Assessment Findings:

Recommendations: (include referrals)

Follow Up:

Anticipatory Guidance: (circle those discussed)

1. Safety/poisons
2. Nutrition
3. Parenting
4. Family Planning
5. Discipline
6. Immunizations
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
11. Sexuality
12. Dental
13. Other

Comments:

Additional Information may be attached

Signature of Licensed Physician or Nurse approved to perform health assessments._____Date_____